NOTICE OF ACTION

State Form 46015 (R4 / 7-99) / HCBS 0005

NOTICE
See the back of this form for important information about your responsibilities and appeal rights.

☐ Aged or Disabled ☐ Autism ☐ ICF / MR ☐ Medically Fragile Children ☐ TBI

Name	Medicaid number
Address	County
City, state, ZIP code	Mailing date of notice *(month, day, year)*

☐ **NEW APPLICATION** ☐ **ANNUAL REDETERMINATION** ☐ **CHANGE / UPDATE**

The Indiana Family and Social Services Administration has taken the action indicated below in regard to your application for, or change of, services under the Home and Community-Based Services (HCBS) Waiver Program.

FOR APPLICATION ONLY

Effective _____, your application for services is: ☐ Approved ☐ Denied

Level of Care

☐ NF / Intermediate ☐ NF / Skilled ☐ ICF / MR ☐ Hospital ☐ NF/TBI

Reason

Please check who approved Level of Care: ☐ State ☐ AAA

FOR ANNUAL REDETERMINATION, CHANGE / UPDATE, AND DISCONTINUANCE ONLY

Effective _____, your waiver for services are: ☐ Increased ☐ Decreased ☐ Continued at same amount ☐ Discontinued

Reason

Description of change

SERVICES APPROVED

PROVIDER - SPECIFY NAME AND ADDRESS	SERVICE	START DATE	STOP DATE	TOTAL HOURS	AVE. HRS / MO.
	Case Management				

Signature of case manager	Case manager's 9 digit authorization number	Date *(month, day, year)*
Address	Case Mgr's 4 digit I.D. number	Telephone number ( )

IF YOU WISH TO APPEAL, PLEASE READ THE INFORMATION ON PAGE 2 AND THEN SIGN AND DATE BELOW.

☐ **I wish to appeal the above decision.**	Reason:
Signature of applicant / recipient / guardian	Date (*month, day, year*)

YOUR APPEAL RIGHTS AS AN HCBS WAIVER SERVICES RECIPIENT

1. If you question the above action, you should discuss this matter with your waiver services case manager.

2. **Your Right to Appeal and Have a Fair Hearing:**
   If your application is denied, you may file an appeal within 30 days of the date the notice is **mailed** to you.

   As an HCBS waiver recipient, if you disagree with any action taken on your HCBS waiver case, you may appeal within 30 days of the **effective date** of the action. However, your HCBS waiver benefits will not continue unless you appeal **prior** to the effective date of action. If you appeal and your waiver benefits are continued and you lose the appeal, you may be required to repay assistance paid in your behalf pending the release of the hearing decision.

3. **How to Request an Appeal:**
   If you wish to appeal this decision, you may request an appeal within 30 days of the date of receipt of this decision. Sign and return this form or send a letter with your signature to: MS04, Indiana Family and Social Services Administration, Hearings and Appeals, 402 W. Washington St., Room W392, Indianapolis, IN 46204

   Be sure that the letter contains your full name, address, and telephone number where you can be reached. Please attach a copy of this decision and state the name of the action you are appealing. If you are unable to write this letter, you may have someone assist you in requesting this appeal. A telephone request for an appeal cannot be accepted.

   You will be notified in writing by the Family and Social Services Administration, Hearings and Appeals of the date, time, and place for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the waiver case manager.

   You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative, or other spokesperson. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference and question, or refute any testimony or evidence presented.

Distribution of Notice of Action:

☐ Recipient ☐ County DFC ☐ Assessment Agency ☐ Provider(s) ☐ Waiver Case File

☐ BDDS Case File ☐ AAA Case File ☐ Other _____